

## Medicaid Purchase Plan (MAPP) Recipient/Premium Information

This form is to be completed by ES workers. It is used for all updates, including recipient demographic information and premium information for MAPP.

### Section I – Recipient Information

Recipient Information (check one) <input type="checkbox"/> Add <input type="checkbox"/> Change	Date Completed	Worker ID
Recipient Name (First, MI, Last, Suffix)		
Mailing Address (Street, City, State, Zip Code)		
Social Security Number	Medicaid ID Number	

### Section II – Premium Information

Premium Information (check one) <input type="checkbox"/> Add <input type="checkbox"/> Change	Date Completed	Premium Payer PIN	
Premium Payer Name (First, MI, Last, Suffix)			
Benefit Month	Premium Amount	Amount Paid	Paid

Please send this form, along with any premium payments due, to:

Medicaid Purchase Plan  
P.O. Box 6738  
Madison, WI 53716-0738

If you have questions, please call the Medicaid Purchase Plan Premium Unit at 1-888-907-4455.